FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044602

Facility Name: OAK PARK HEALTHCARE CENTER

Address: 625 N HARLEM (Number) OAK PARK (City) 60302 (Zip Code)

County: COOK

Telephone Number: (847) 647-1717 **Fax #** (847) 647-0222

IDPA ID Number: 36-4303161

Date of Initial License for Current Owners: 11/01/99

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHERWIN I. RAY
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	176	Skilled (SNF)	176	64,416	1
2		Skilled Pediatric (SNF/PED)			2
3	28	Intermediate (ICF)	28	10,248	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	204	TOTALS	204	74,664	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,663		2,444	4,107	8
9	SNF/PED					9
10	ICF	42,615	1,154		43,769	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,278	1,154	2,444	47,876	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.12%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/99

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/99 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 2,444

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	209,041	20,564	13,376	242,981		242,981	(1,335)	241,646			1
2	Food Purchase		195,331		195,331	(13,835)	181,496	(294)	181,202			2
3	Housekeeping	136,727	38,267		174,994		174,994		174,994			3
4	Laundry	67,790	15,866		83,656		83,656		83,656			4
5	Heat and Other Utilities			138,514	138,514		138,514	663	139,177			5
6	Maintenance	50,576	26,203	50,340	127,119		127,119	7,760	134,879			6
7	Other (specify):*			11,167	11,167		11,167	348	11,515			7
8	**TOTAL General Services**	464,134	296,231	213,397	973,762	(13,835)	959,927	7,142	967,069			8
	B. Health Care and Programs											
9	Medical Director			4,500	4,500		4,500		4,500			9
10	Nursing and Medical Records	1,582,605	79,792	161,284	1,823,681		1,823,681	(124,496)	1,699,185			10
10a	Therapy	49,661	3,322	54,443	107,426		107,426	(44,443)	62,983			10a
11	Activities	76,247	11,189	1,169	88,605		88,605		88,605			11
12	Social Services	163,440		784	164,224		164,224		164,224			12
13	Nurse Aide Training											13
14	Program Transportation			310	310		310		310			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,871,953	94,303	222,490	2,188,746		2,188,746	(168,939)	2,019,807			16
	C. General Administration											
17	Administrative	125,921			125,921		125,921	68,374	194,295			17
18	Directors Fees											18
19	Professional Services			346,383	346,383		346,383	(258,622)	87,761			19
20	Dues, Fees, Subscriptions & Promotions			66,677	66,677		66,677	(21,954)	44,723			20
21	Clerical & General Office Expenses	92,933	12,853	189,236	295,022		295,022	(86,065)	208,957			21
22	Employee Benefits & Payroll Taxes			475,307	475,307	13,835	489,142		489,142			22
23	Inservice Training & Education			1,665	1,665		1,665	1,227	2,892			23
24	Travel and Seminar							404	404			24
25	Other Admin. Staff Transportation			5,661	5,661		5,661	4,075	9,736			25
26	Insurance-Prop.Liab.Malpractice			166,199	166,199		166,199	2,564	168,763			26
27	Other (specify):*							45,199	45,199			27
28	**TOTAL General Administration**	218,854	12,853	1,251,128	1,482,835	13,835	1,496,670	(244,798)	1,251,872			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,554,941	403,387	1,687,015	4,645,343		4,645,343	(406,595)	4,238,748			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: OAK PARK HEALTHCARE CENTER #0044602 **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	10,930	
	REPAIRS & MAINTENANCE		2,446	
			0	13,376
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		75,369	
	ELECTRICITY		49,447	
	WATER		13,698	
	CABLE TV - LOBBY		0	
			0	138,514
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		6,649	
	PAINTING & DECORATING		400	
	BUILDING REPAIRS		1,250	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		24,485	
	ELEVATOR MAINTENANCE & REPAIR		5,393	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,295	
	FIRE SERVICE		7,868	
			0	
			0	
			0	50,340
7	**OTHER**			
	SCAVENGER		11,167	
	SECURITY SERVICE		0	11,167
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	4,500	4,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	0	
	LABORATORY & XRAY EXPENSE		104	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,760	
	PHARMACY CONSULTANT	XVIII B 39-2	450	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B 48-2	0	
	PSYCHIATRIC	XVIII B 47-2	50,000	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL SERVICES		8,970	
	MEDICARE & PUBLIC AID CONSULTAN		100,000	161,284
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		7,716	
	SPEECH THERAPY SERVICES		1,202	
	OCCUPATIONAL THERAPY SERVICES		4,325	
	THERAPY CONTRACT SERVICES		26,800	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	7,200	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	7,200	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	54,443
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,169	
			0	1,169
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	784	
			0	784
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number OAK PARK HEALTHCARE CENTER **#0044602** **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		310	310
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	25,538	
	ADMINISTRATIVE CONSULTANTS	XIX C	248,000	
	PROFESSIONAL FEES	XIX C	72,845	
			0	346,383
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	22,262	
	EMPLOYEE WANT ADS	XIX F	33,846	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	5,672	
	LICENSES & PERMITS	XIX F	2,212	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,935	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	700	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	50	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	66,677
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		9,012	
	OUTSIDE CLERICAL SERVICES		122,400	
	PENALTIES / OVERDRAFT CHARGES	VI 18	35,463	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		87	
	TELEPHONE		20,876	
	MESSENGER SERVICE		1,398	
			0	189,236

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	192,962	
	UNEMPLOYMENT COMPENSATION	XIX D	102,559	
	WORKERS COMPENSATION INSURANCI	XIX D	60,743	
	HOSPITALIZATION INSURANCE	XIX D	90,914	
	EMPLOYEE BENEFITS - OTHER	XIX D	28,129	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	475,307
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,665	1,665
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		5,661	5,661
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		166,199	166,199
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 1,687,015

OAK PARK HEALTHCARE CENTER
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	195,331	PATIENT MEALS	143628
LESS SALES TAX	(294)	ADD EMPLOYEE MEALS	10980
NET FOOD	195,037	TOTAL MEALS/YEAR	154608
TOTAL PATIENT CENSUS	47,876	NET FOOD	195037
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	154608
TOTAL PATIENT MEALS	143628	COST PER MEAL	1.26
		TIME EMPLOYEE MEALS	10980
ADD # EMPLOYEE MEALS/DAY	30		
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	13835
TOTAL EMPLOYEE MEALS	10980		

OAK PARK HEALTHCARE CENTER INC
EDUCATION & SEMINAR
12/31/04 **ACCT #18180**

DATE	INV	SPONSOR	DESCRIPTION	PERSONNEL ATTENDING	LOC	COST
1.04	X	ICLTC	PAIN MANAGEMENT: PUTTING THEORY INTO PRACTICE	THERESA HAIL	IL	95.00
				CARMEN CUA	IL	95.00
				JEFF KALKOWSKI	IL	95.00
				NORA TABRON	IL	95.00
2.04	X	ICLTC	NEW ENFORCEMENT OF SUBPART S	THERESA HAIL	IL	95.00
				CARMEN CUA	IL	95.00
				JEFF KALKOWSKI	IL	95.00
				NORA TABRON	IL	95.00
				MICHAEL MUTTERER	IL	95.00
				KARLA ISMAY	IL	95.00
				ARLENE MANZANO	IL	95.00
				DAVEED RINE	IL	95.00
3.04		ICLTC - REFUND	REIMBURSEMENT FOR 3 ATTENDEES (3 X 95.00)			(285.00)
3.04		C.C.P. SANITATION			IL	240.00
3.04	X	ICLTC	THE WITNESS STAND: EVERY NURSE'S NIGHTMARE	THERESA HAIL	IL	95.00
				CARMEN CUA	IL	95.00
				JEFF KALKOWSKI	IL	95.00
5.04	X	ICLTC	MANAGING CUSTOMER EXPECTATIONS THROUGH	JEFF KALKOWSKI	IL	95.00
			ADMISSIONS AND BEYOND	DAVEED RINE	IL	95.00
				ROMY MACASAET JR.	IL	95.00
TOTAL						1,665.00

OAK PARK HEALTHCARE CENTER INC
EQUIPMENT RENTAL
12/31/04

VENDOR	DESCRIPTION	AMOUNT
KREG THERAPEUTICS	NURSING EQUIPMENT	$ 38,016
MEDICAL SPECIALTIES	NURSING EQUIPMENT	108
RCS MGMT	NURSING EQUIPMENT	2,352
ADVANTA LEASING SERVICES	DIGITAL PLAYER	78
JOHNSON WATER CONDITIONING	PLANT EQUIPMENT	360
FAMILY PRIDE	WASHER/DRYER	9,996
NEOPOST	OFFICE EQUIPMENT	813
TOSHIBA AMERICA	COPIER	2,438
		54,161
CAREPLUS REHAB	EQUIPMENT LEASE	19,116
		73,277

OAK PARK HEALTHCARE CENTER INC
PROFESSIONAL FEES
12/31/04

VENDOR	DESCRIPTION	AMOUNT
AMERICAN DATA	DATA PROCESSING	$ 3,191
ACHIEVE HEALTHCARE	DATA PROCESSING	3,997
E-HEALTH DATA SOLUTIONS	DATA PROCESSING	930
NATIONAL DATACARE	DATA PROCESSING	3,020
CAREPLUS MANAGEMENT	DATA PROCESSING	14,400
CAREPLUS MANAGEMENT	ADMINISTRATIV CONSULTANT	248,000
KRUPNICK, BOKOR, KAGDA & BROOKS	ACCOUNTING	29,400
CSC	LEGAL	608
FEDERATED MEDIATION	LEGAL	25
SACHNOFF & WEAVER	LEGAL	4,200
MEYER MAGENCE	LEGAL	12,868
RECORD COPY SERVICE	LEGAL	1,664
MYERS MILLER	LEGAL	17,000
PERSONNEL PLANNERS	UC CONSULTANT	2,280
RICHARD PEELO	MEDICARE CONSULTANT	4,800
	TOTAL	346,383

OAK PARK HEALTHCARE CENTER INC
TRANSPORTATION - STAFF
12/31/04 **G/L #18370**

	JEFF KALKOWSKI	DARYCE FIELDS	JOLENE LONA	CHERYL GARCIA	TOTAL
JAN	316.67		153.36		470.03
FEB	396.17		345.36		741.53
MAR	366.67				366.67
APR	316.67				316.67
MAY	366.47				366.47
JUN	316.67				316.67
JUL	411.67				411.67
AUG	316.67	121.28			437.95
SEP	316.67	112.64			429.31
OCT	520.42	104.32			624.74
NOV	406.31	98.56			504.87
DEC	363.67	35.88		274.75	674.30
TOTAL	4,098.06	472.68	345.36	274.75	5,660.88

GASOLINE FOR FACILITY BANKING, MAINTENANCE, MARKETING, AND ACTIVITIES

Facility Name & ID Number OAK PARK HEALTHCARE CENTER #0044602 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			37,051	37,051		37,051	1,715	38,766			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			259,123	259,123		259,123	28,163	287,286			32
33	Real Estate Taxes			265,017	265,017		265,017		265,017			33
34	Rent-Facility & Grounds			707,370	707,370		707,370	6,034	713,404			34
35	Rent-Equipment & Vehicles			73,277	73,277		73,277	(12,569)	60,708			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,341,838	1,341,838		1,341,838	23,343	1,365,181			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		135,417	105,049	240,466		240,466	(87,861)	152,605			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,996	111,996		111,996		111,996			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		135,417	217,045	352,462		352,462	(87,861)	264,601			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,554,941	538,804	3,245,898	6,339,643		6,339,643	(471,113)	5,868,530			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,123)	30		9
10	Interest and Other Investment Income	(60)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(294)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(700)	20		17
18	Fines and Penalties	(35,463)	21		18
19	Entertainment				19
20	Contributions	(50)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(22,262)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,935)	20		28
29	Other-Attach Schedule	(29,711)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (98,598)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(372,515)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (372,515)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (471,113)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

OAK PARK HEALTHCARE CENTER

ID# 0044602

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 1003	6	1
2	MARKETING SALARY	(30,714)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(29,711)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	(1,335)	0	0	0	0	0	0	0	0	0	(1,335)	1
2	Food Purchase	(294)	0	0	0	0	0	0	0	0	0	0	(294)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	663	0	0	0	0	0	0	0	0	0	663	5
6	Maintenance	1,003	6,757	0	0	0	0	0	0	0	0	0	7,760	6
7	Other (specify):*	0	0	348	0	0	0	0	0	0	0	0	348	7
8	**TOTAL General Services**	709	6,085	348	0	0	0	0	0	0	0	0	7,142	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(124,496)	0	0	0	0	0	0	0	0	0	(124,496)	10
10a	Therapy	0	3,369	(47,812)	0	0	0	0	0	0	0	0	(44,443)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(121,127)	(47,812)	0	0	0	0	0	0	0	0	(168,939)	16
	C. General Administration													
17	Administrative	0	68,374	0	0	0	0	0	0	0	0	0	68,374	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(262,400)	3,778	0	0	0	0	0	0	0	0	(258,622)	19
20	Fees, Subscriptions & Promotions	(24,947)	0	2,993	0	0	0	0	0	0	0	0	(21,954)	20
21	Clerical & General Office Expenses	(66,177)	(122,400)	102,512	0	0	0	0	0	0	0	0	(86,065)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	1,227	0	0	0	0	0	0	0	0	1,227	23
24	Travel and Seminar	0	0	404	0	0	0	0	0	0	0	0	404	24
25	Other Admin. Staff Transportation	0	0	4,075	0	0	0	0	0	0	0	0	4,075	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,564	0	0	0	0	0	0	0	0	2,564	26
27	Other (specify):*	0	0	45,199	0	0	0	0	0	0	0	0	45,199	27
28	**TOTAL General Administration**	(91,124)	(316,426)	162,752	0	0	0	0	0	0	0	0	(244,798)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(90,415)	(431,468)	115,288	0	0	0	0	0	0	0	0	(406,595)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(8,123)	0	9,838	0	0	0	0	0	0	0	0	1,715	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(60)	0	28,223	0	0	0	0	0	0	0	0	28,163	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	6,034	0	0	0	0	0	0	0	0	6,034	34
35	Rent-Equipment & Vehicles	0	0	(12,569)	0	0	0	0	0	0	0	0	(12,569)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(8,183)	0	31,526	0	0	0	0	0	0	0	0	23,343	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	(87,861)	0	0	0	0	0	0	0	0	(87,861)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	(87,861)	0	0	0	0	0	0	0	0	(87,861)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(98,598)	(431,468)	58,953	0	0	0	0	0	0	0	0	(471,113)	45

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT	SKOKIE	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
SEE ATTACHED SCHEDULES					SKOKIE	THERAPY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$	CAREPLUS MGMT INC		$	$	1
2	V	19	ADMIN. CONSULTANT FEES	248,000	" "			(248,000)	2
3	V	19	DATA PROCESSING FEES	14,400	" "			(14,400)	3
4	V	21	CLERICAL FEES	122,400	" "			(122,400)	4
5	V	1	DIETARY CONSULTANT FEES	4,200	" "			(4,200)	5
6	V	10	M/C,PA,PSYCH FEES	150,000	" "			(150,000)	6
7	V	1	DIETARY SALARIES		" "		2,865	2,865	7
8	V	5	ELECTRICITY		" "		663	663	8
9	V	6	REPAIRS		" "		23	23	9
10	V	6	MAINTENANCE SALARIES		" "		6,734	6,734	10
11	V	10	NURSING		" "		25,504	25,504	11
12	V	10a	THERAPY SALARIES		" "		3,369	3,369	12
13	V	17	ADMIN SALARIES		" "		68,374	68,374	13
14	Total			$ 539,000			$ 107,532	$ * (431,468)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	CAREPLUS MGMT INC		$ 3,778	$ 3,778	15
16	V	20	DUES/LICENSES/WANT ADS		" "		2,993	2,993	16
17	V	21	OFFICE SALARIES/EXPENSES		" "		102,512	102,512	17
18	V	23	SEMINARS		" "		1,227	1,227	18
19	V	24	TRAVEL		" "		404	404	19
20	V	25	TRANSPORTATION		" "		4,075	4,075	20
21	V	26	INSURANCE		" "		2,564	2,564	21
22	V	27	EMPLOYEE BENEFITS		" "		45,199	45,199	22
23	V	30	SL DEPRECIATION		" "		9,838	9,838	23
24	V	32	INTEREST		" "		28,223	28,223	24
25	V	34	OFFICE RENT		" "		6,034	6,034	25
26	V	35	EQUIP RENT/AUTO LEASE		" "		6,547	6,547	26
27	V	7	SECURITY		" "		348	348	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V	10a	THERAPY SERVICES	54,441	CAREPLUS REHABILITATIVE SERVICES		6,629	(47,812)	35
36	V	39	ANCILLARY THERAPY	105,048	" "		17,187	(87,861)	36
37	V	35	EQUIPMENT RENT EXPENSE	19,116	" "			(19,116)	37
38	V				" "				38
39	Total			$ 178,605			$ 237,558	$ * 58,953	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								$		1
2	SHERWIN RAY	PRESIDENT	ADMIN/FINANCE	50.00	SEE ATTACHED	5.1	8.46	SALARY	15,660	17-7	2
3	JAKOB BAKST	DIR OPERAT'NS	ADMIN/CONS.	50.00	SCHEDULES	5.1	8.46	" "	15,660	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 31,320		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MANAGEMENT INC
Street Address: 5940 W TOUHY
City / State / Zip Code: NILES 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS	451,049	9 FACILITIES	$ 26,990	$ 26,990	47,876	$ 2,865	1
2	5	ELECTRICITY	" "	565,586	13 FACILITIES	7,834		47,876	663	2
3	6	REPAIRS	" "	565,586	13 FACILITIES	275		47,876	23	3
4	6	MAINTENANCE SALARIES	" "	565,586	13 FACILITIES	79,548	79,548	47,876	6,734	4
5	10	NURSING	" "	565,586	13 FACILITIES	301,295	301,295	47,876	25,504	5
6	10a	THERAPY SALARIES	" "	565,586	13 FACILITIES	39,798	39,798	47,876	3,369	6
7	17	ADMIN SALARIES	" "	565,586	13 FACILITIES	807,745	807,745	47,876	68,374	7
8	19	PROFESSIONAL FEES	" "	565,586	13 FACILITIES	44,637		47,876	3,778	8
9	20	DUES/LICENSES/WANT ADS	" "	565,586	13 FACILITIES	35,362		47,876	2,993	9
10	21	OFFICE SALARIES/EXPENSES	" "	565,586	13 FACILITIES	1,211,025	819,289	47,876	102,512	10
11	23	SEMINARS	" "	565,586	13 FACILITIES	14,490		47,876	1,227	11
12	24	TRAVEL	" "	565,586	13 FACILITIES	4,769		47,876	404	12
13	25	TRANSPORTATION	" "	565,586	13 FACILITIES	48,136		47,876	4,075	13
14	26	INSURANCE	" "	565,586	13 FACILITIES	30,286		47,876	2,564	14
15	27	EMPLOYEE BENEFITS	" "	565,586	13 FACILITIES	533,964		47,876	45,199	15
16	30	SL DEPRECIATION	" "	565,586	13 FACILITIES	116,219		47,876	9,838	16
17	32	INTEREST	" "	565,586	13 FACILITIES	333,416		47,876	28,223	17
18	34	OFFICE RENT	" "	565,586	13 FACILITIES	71,288		47,876	6,034	18
19	35	EQUIP RENT/AUTO LEASE	" "	565,586	13 FACILITIES	77,344		47,876	6,547	19
20	7	SECURITY	" "	565,586	13 FACILITIES	4,112		47,876	348	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,788,533	$ 2,074,665		$ 321,274	25

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	CAREPLUS MANAGEMENT ALLOCATION: LOC, ETC						$	$			$ 28,223	1
2												2
3												3
4	CAREPLUS MGMT - CIB BK	X		CAPL IMPR LOAN FEES	5 YR AMORT	2/23/01	2,475		W/O BAL		1,073	4
5	CAREPLUS MGMT - CIB BK	X		CAPITAL IMPROVEMENT	$5,572.35	01/04	234,551	186,135	01/09	PRIME+	26,421	5
	Working Capital											
6	CAREPLUS MGMT - CIB BK	X		WORKING CAPITAL	DEMAND	Nov-99	1,925,000	4,095,925		PRIME+	231,629	6
7												7
8												8
9	TOTAL Facility Related				$5,572.35		$ 2,162,026	$ 4,282,060			$ 287,346	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,162,026	$ 4,282,060			$ 287,346	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 277,580	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 269,947	2
3. Under or (over) accrual (line 2 minus line 1).		$ (7,633)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 272,650	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 265,017	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	285,617	8
	2000	295,825	9
	2001	324,378	10
	2002	274,833	11
	2003	269,947	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OAK PARK HEALTHCARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044602

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-07-106-004-0000	NURSING HOME	$ 53,819.81	$ 53,819.81
2.	16-07-106-005-0000	NURSING HOME	$ 51,499.61	$ 51,499.61
3.	16-07-106-022-0000	NURSING HOME	$ 164,627.51	$ 164,627.51
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 269,946.93	$ 269,946.93

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,926 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 2+BASEMENT/ 3

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	22,950		$	1
2					2
3	TOTALS	22,950		$	3

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	NEW WINDOWS / LIGHT FIXTURES / GENERATOR			1999	74,653	1,914	39	1,914		9,665	9
10	WINDOWS / FENCE / CEILING			2000	13,360	486	27.5	486		2,410	10
11	WINDOWS / SIGNS / FLOORING / WALLPAPER			2000	42,672	1,552	27.5	1,552		7,539	11
12	WINDOWS /FLOORING /WALLPAPER / NURSE STATION			2000	29,709	1,080	27.5	1,080		5,085	12
13	FLOORING / DOORS /WALLS /HVAC SYSTEM			2000	56,310	2,047	27.5	2,047		9,468	13
14	WINDOWS / FLOORING / RAILS / ASPHALT PAVING			2000	30,160	1,096	27.5	1,096		4,938	14
15	WINDOWS / PLUMBING / PAINTING & DECORATING			2000	41,459	1,508	27.5	1,508		6,420	15
16	WINDOW TREATMENTS			2000	15,445	1,379	15	1,030	(349)	4,635	16
17	WINDOWS/WALK-IN FREEZER, ROOF & A/C REPAIRS			2001	23,850	868	27.5	868		3,196	17
18	WINDOWS//FLOORING/ALARM & PAGING SYSTEM			2001	9,926	361	27.5	361		1,121	18
19	WINDOWS/DOORS/GREASE TRAP/ROOF A/C			2002	62,212	2,266	27.5	2,266		5,671	19
20	WINDOWS/BACKFLOW PREVENTORS/AC TOWER BEARING			2003	16,526	603	27.5	603		1,061	20
21	DOORS/CIRCUITS/ROOFTOP A/C MOTORS			2004	7,532	223	27.5	223		223	21
22	WINDOWS			2004	7,200	64	27.5	64		64	22
23	REMODEL MOLDINGS/HANDRAILS/CABINETRY/DECOR			2004	68,233	669	27.5	669		669	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	RELATED PARTY ALLOCATION - CAREPLUS MGMT					100		100			34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 499,247	$ 16,216		$ 15,867	$ (349)	$ 62,165	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 117,310	$ 14,608	$ 12,749	$ (1,859)	8-15 YRS	$ 44,146	71
72	Current Year Purchases	10,544	6,327	412	(5,915)	10-15 YRS	412	72
73	Fully Depreciated Assets							73
74	** RELATED PARTY - SL DEPN: CAREPLUS MGMT 9,738		9,738	9,738				74
75	TOTALS	$ 127,854	$ 30,673	$ 22,899	$ (7,774)		$ 44,558	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 627,101	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 46,889	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 38,766	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (8,123)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 106,723	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: FAIRMOUNT OF OAK PARK LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		204	11/01/99	$ 707,370			3
4	Additions							4
5								5
6								6
7	TOTAL		204		$ 707,370 **			7

10. Effective dates of current rental agreement:
Beginning 11/01/99
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 73,277 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 37,166	$		$ 37,166	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,363			2,363	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			58,226			58,226	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				74,151		74,151	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-2				7,294	48,272		55,566	12
13	MED.SUPPLIES/LAB/RENTALS Other (specify):	39-2					12,994		12,994	13
14	TOTAL			$		$ 105,049	$ 135,417		$ 240,466	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000)	1,943,973		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	67,806		6
7	Other Prepaid Expenses	17,905		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): R.E,TAX ESCROW	267,362		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,297,046	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	485,800		15
16	Equipment, at Historical Cost	142,742		16
17	Accumulated Depreciation (book methods)	(169,941)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DUE FROM LLC	10,484		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 469,085	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,766,131	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 788,146	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	29,073		28
29	Short-Term Notes Payable	4,095,925		29
30	Accrued Salaries Payable	93,755		30
31	Accrued Taxes Payable (excluding real estate taxes)	25,668		31
32	Accrued Real Estate Taxes(Sch.IX-B)	272,650		32
33	Accrued Interest Payable	16,437		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,321,654	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	186,135		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 186,135	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,507,789	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,741,658)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,766,131	$	48

*(See instructions.)

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,613,020)	1
2	Restatements (describe):		2
3			3
4	POST-CLOSING INSURANCE ADJ	(63,141)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,676,161)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,065,497)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,065,497)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,741,658)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,273,766	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,273,766	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	320	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 320	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	60	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 60	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,274,146	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	973,762	31
32	Health Care	2,188,746	32
33	General Administration	1,482,835	33
	B. Capital Expense		
34	Ownership	1,341,838	34
	C. Ancillary Expense		
35	Special Cost Centers	240,466	35
36	Provider Participation Fee	111,996	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,339,643	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,065,497)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,065,497)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,885	2,096	$ 59,762	$ 28.51	1
2	Assistant Director of Nursing	1,845	2,020	56,345	27.89	2
3	Registered Nurses	13,735	14,083	344,616	24.47	3
4	Licensed Practical Nurses	20,822	21,692	436,018	20.10	4
5	Nurse Aides & Orderlies	65,787	71,492	667,739	9.34	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,300	5,567	49,661	8.92	8
9	Activity Director	2,014	2,176	21,408	9.84	9
10	Activity Assistants	6,712	7,292	54,839	7.52	10
11	Social Service Workers	8,981	9,334	163,440	17.51	11
12	Dietician					12
13	Food Service Supervisor	2,060	2,190	37,794	17.26	13
14	Head Cook	4,777	5,373	52,066	9.69	14
15	Cook Helpers/Assistants	13,923	14,805	119,181	8.05	15
16	Dishwashers					16
17	Maintenance Workers	5,136	5,506	50,576	9.19	17
18	Housekeepers	16,033	17,302	136,727	7.90	18
19	Laundry	7,491	8,197	67,790	8.27	19
20	Administrator	1,948	2,095	82,740	39.49	20
21	Assistant Administrator	1,930	1,993	43,181	21.67	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,291	5,750	62,219	10.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,738	1,936	18,125	9.36	31
32	Other Health Care(specify)					32
33	Other(specify) MARKETING	1,401	1,435	30,714	21.40	33
34	TOTAL (lines 1 - 33)	188,809	202,334	$ 2,554,941 *	$ 12.63	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 10,930	1-3	35
36	Medical Director	O	4,500	9-3	36
37	Medical Records Consultant	N	1,760	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	450	10-3	39
40	Physical Therapy Consultant	L	7,200	10a-3	40
41	Occupational Therapy Consultant	Y	7,200	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,169	11-3	44
45	Social Service Consultant	E	784	12-3	45
46	Other(specify)	S			46
47	PSYCHIATRIC		50,000	10-3	47
48	M/C & PA CONSULTING		100,000	10-3	48
49	TOTAL (lines 35 - 48)		$ 183,993		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0		50
51	Licensed Practical Nurses		0		51
52	Nurse Aides		0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JEFFREY KALKOWSKI	ADMIN	0	$ 82,740
DAVID RINE	ASST ADMIN	0	8,632
SUZANNE BLANCHARD	ASST ADMIN	0	34,549
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 125,921

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		346,383
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 346,383

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 60,743
Unemployment Compensation Insurance		102,559
FICA Taxes		192,962
Employee Health Insurance		90,914
Employee Meals		13,835
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		28,129
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 489,142

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	33,846
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	24,197
TRUST/FRANCHISE/CONTRIB/ETC	750
LICENSES & PERMITS	2,212
DUES & SUBSCRIPTIONS	5,672
MGMT CO ALLOCATION	2,993
TRUST/FRANCHISE/CONTRIB/ETC	(750)
Less: Public Relations Expense	(0)
Non-allowable advertising	(22,262)
Yellow page advertising	(1,935)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 44,723

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL & LODGING	0
MGMT CO ALLOCATION	404
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 404

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINT/DECORATING	2001	$ 2,847	3	$ 475	$ 949	$ 949	$ 474	$	$	$	$	$
2	PAINT/DECORATING	2002	1,587	3		265	529	529	264				
3				3									
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 4,434		$ 475	$ 1,214	$ 1,478	$ 1,003	$ 264	$	$	$	$

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL ASSOC HEALTHCARE FACIL $1,020**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,282** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **111,996**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **13,835** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees